

Therapeutic Touch - principles and practice

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SUMMARY. Many health care professionals in the UK, especially nurses, have shown increasing interest in the concept and applications of Therapeutic Touch (TT). This paper explores the background to TT, including relevant working models, defines its actions and reviews the main research findings which support its use. A growing body of research now offers a rationale for the application of the practice of TT and the paper discusses some of the implications for practitioners.

INTRODUCTION

Modern physicists now see the universe as a dynamic web of interrelated events, none of which functions in isolation.¹ The view of humans and the environment as being inseparable and co-extensive with the universe has always been a fundamental component of major Eastern philosophies.^{2,3} The work of Rogers uses this same theme in developing a theory of nursing.⁴ She writes, "The human field extends beyond the discernible mass which we perceive as man.... and is co-extensive with the environmental field".

THEORY

Martha Rogers, who spent 21 years as Professor and Head of the Division of Nurse Education at New York University, becoming Professor Emeritus of the same in 1975, first published the seeds of a conceptual framework of what would become the *Science of Unitary Human Beings* in 1964. Biley⁵ writes of Rogers' theory:

'This theory provided a radical vision of nursing reality which advocates a move away from a predominant medical model into a nursing model. The framework provides an alternative to the traditional view of nursing which could be described as Cartesian, that is reductionistic, mechanistic and analytic, consisting of breaking up thoughts and problems into pieces and arranging these in their logical order. It has guided nursing out of a concrete, static, closed system world view and as a result has challenged many preconceived ideas about nursing and beyond.'

Since the 1960s, Rogers' work has moved from being called an 'outrageous nursing theory', the complexity of which is 'difficult to understand'⁶ to a 'brilliant nursing theory without which it would be difficult to imagine what nursing would look like today'.⁷ It guides nurses into a more holistic approach which draws from a vast array of subjects other than nursing, including anthropology, astronomy, mathematics, Einsteinian physics and philosophy.

This *Science of Unitary Human Beings* is the nursing theory on which the concepts of Therapeutic Touch (TT) are based. Simplified it states that

- Human beings *are* energy fields - not *have* energy fields but *are* energy fields.
- Humans and the environment are continually, simultaneously, and mutually exchanging energy with each other (environment refers to everything exterior to human, including other people).
- Universal order is a force innate to all energy fields.⁸

In Eastern mysticism, this universal interwovenness always includes a human observer and his/her consciousness. As in

atomic physics also, the scientist cannot play the role of an objective observer, but becomes involved in the world he/she observes to the extent that he/she influences the properties of the observed objects. This involvement is seen as the most important feature of quantum theory. So too, the act of TT includes a human facilitator the nurse or practitioner.

Using these basic concepts TT can be viewed as an energy field interaction, the role of practitioners being to observe and re-pattern the energy field of their patients, therefore promoting relaxation and pain relief. The practitioner's level of consciousness would therefore be a central factor and, indeed, a part of the process is becoming 'centred' - becoming mentally relaxed and focused on the patient.

PHASES

The phases of TT, although learned sequentially by beginners, are dynamic and often performed concurrently and repetitively by experienced practitioners.

These phases are as follows:

Centreing

Practitioners describe centreing as a method for (a) disciplining attention, (b) achieving calm, and (c) establishing receptivity⁹. It is a focusing on the here and now, placing oneself in a calm, alert, open state. It involves having a clear sense of oneself as a unitary whole and differs from concentration or paying attention in that it is not associated with mental effort. It brings the patient and practitioner into harmony with one another and so mobilizes the process. Centreing is paramount to proceeding with the remaining phases and is necessary for the intervention to be effective. Being unable to become or stay centred causes the practitioner to feel depleted of energy, tired and ineffectual. Many practitioners find meditation a useful practice for being able to become and stay centred.

Assessment

This is an act in which the practitioners use their hands to determine the nature of the dynamic energy field. This is perceived by the practitioner as subtle sensations which are highly subjective. Lionberger found that during assessment practitioners also perceive information about the patient through intuitive and somatic clues, and that the more experienced practitioners rely more on these than on sensation in the hands.⁹ The differences perceived may or may not have relevance to the current status of the physical body. Krieger describes assessment as 'the underlying basis for the whole act of energy transfer'.¹⁰

Clearing

This phase is using the hands to facilitate the symmetrical and rhythmical flow of energy through the field. It is done by sweeping the hands, just above the body, downward. This is

done over the entire body, with concentration over the areas of imbalance identified during the assessment. In Krieger's¹⁰ view it is in this phase that the patients mobilize their own resources so that self healing can occur. It is commonly reported that responses indicative of relaxation occur most frequently during this phase. When the patient is experiencing anxiety or discomfort, or pain of a physical or emotional nature, it is in this phase that these symptoms may diminish. Indeed, many practitioners believe this action not to be a separate phase but part of the intervention or balancing phase.

Intervention or balancing

Practitioners describe this phase as the act of projecting, directing and modulating energy based on the nature of the living energy field: assisting to re-establish the order in the system; and repatterning the energy field, always motivated by an interest in the needs of the patient. The practitioner continues to smooth and balance the energy field over areas where congestion or imbalances persist, feeling his/her self continually, simultaneously and mutually a part of the whole process. During this phase, the practitioner often relies heavily on imagery to conceptualize areas of imbalance and to symbolize and direct the flow of energy.

Evaluation

The phase in which professional, informed and intuitive judgement is used to determine if the repatterning or rebalancing is complete.

RESEARCH

Some of the first research on TT was carried out in 1961 by Grad,¹¹ a Canadian biochemist at McGill University. His work involved the use of laboratory animals and plants. His research suggested that the laying on of hands could accelerate wound healing. He did this by removing skin from the backs of 300 mice and dividing them into two groups - a treated group and an untreated group. He used a well-known healer by the name of Oskar Estebany for the treated group and a person who knew nothing about healing for the untreated group. Results showed that the mice treated by Estebany had wound healing significantly accelerated. Grad also worked with barley seeds,¹² having Estebany hold his hands over a beaker of saline solution which was then used to water a third of the seeds - another third were watered with untreated saline and the remainder with saline held by a second (non-healer) person. The seedlings given water treated by Estebany grew faster, stronger and taller. Grad replicated this study many times. He went from beakers of saline, to stoppered beakers of saline, to sealed bottles of saline, to sealed bottles of saline inside taped paper bags, trying to work out variables and eliminate these variables systematically. The conclusion at the end of the experiments from the perspective of a biochemist was that there must be some kind of energy involved that was able to penetrate glass and influence the plants when Estebany was not present. Since that time biochemists have looked at water held by healers and have found a difference in the hydrogen bonding in the water.¹³

A contemporary of Grad, Smith,¹⁴ in her first study found that the laying on of hands would accelerate the activity level of selected enzymes. Upon replication, she found it seemed to slow down the level, so it looked at first as if there were inconsistent findings. However, in the end, what she realized was that laying on of hands was affecting each enzyme in a way specifically helpful to that enzyme. (Enzymes have different activity rates, and laying on of hands seemed to cause each

enzyme to react in a unique way, according to their needs.)

This study must be kept in mind when practising TT, as it suggests a considerable degree of unpredictability in the effect on the patient. The practitioner appears to facilitate the energy but the patient's system will use it how it needs it. There is evidence in the research data to support that patients will respond differently.

These studies preceded Krieger's haemoglobin studies of 1972.¹⁵ These first studies using laying on of hands with humans demonstrated an increase in haemoglobin levels. However, these studies were not methodologically strong enough to be convincing, and need to be replicated.

It was at this time that Krieger, Professor of Nursing at New York University, began to develop this technique for her nursing students. She coined the name "Therapeutic Touch" and began to teach this healing art in her master's degree programme. *Frontiers in Nursing*. Since that time TT has been taught to thousands of nurses in 36 countries. Serious practitioners of TT use a carefully chosen language when speaking about this healing art. This, combined with the extensive research, done mostly by nurses in the US for their master's and doctoral thesis, has made TT part of mainstream nursing practice in the US.

One of the most recent studies, followed along the lines of Grad's first study. Wirth,¹⁶ the researcher, examined the healing rates of a punch biopsy administered by a physician to 46 volunteers. Using a randomized, double blind, placebo controlled protocol, the effect of non-contact TT was observed. The physician who performed the biopsies and the technician who organized the daily sessions, and measured the wounds, thought they were participating in a study that monitored the bioelectric properties of healing. Only the TT practitioner and the author knew the true nature of the experiment. They were isolated from the participants for the length of the study. Suggestion and placebo effect were ruled out by the research design. Each of the participants was placed in an isolated room and instructed to place his/her arm through a sleeve fitted to an opening in the wall. He/she could not see into the second room where the TT practitioner conducted the 5 min session. The untreated control group inserted their wounded arms into an empty room. The sessions were repeated for both groups daily for 16 days. The wound was measured on the day of the biopsy, on day 8 and on day 16. The size of the wound was identical for all participants on day 1. By day 8, the TT group had an average wound size 10 times smaller than the untreated group. By day 16, the average size of the treated wounds was 0.418 mm², and the average size of the untreated wounds was 5.855 mm². 13 of the 23 subjects treated by TT were completely healed by day 16. None of the untreated group was healed.

Research carried out by Heidt¹⁷ involved 90 volunteers who were patients in a hospital cardiovascular unit of a large medical centre in New York. The patients were divided into three matched groups. Each subject received an individual 5 min period of intervention. The dependent variable of patient's anxiety was measured before and after the intervention. One group received TT as taught by Krieger. The second group received casual touch through the taking of routine apical, radial and pedal pulses. The third group were not touched but were given 5 min focused conversation starting with 'Can you tell me how you are feeling today?'. The patients in the TT group experienced a highly significant reduction in stated anxiety according to pre- and post-test comparisons, a markedly greater reduction than subjects who received intervention by casual touch or who were not touched at all.

It was argued that this reduction in patients' anxiety and the sense of relaxation that accompanied it was a result of the nurses' hand movements. It was further argued that these movements or hand passes could be hypnotic in themselves and so produced this effect Quinn tested this hypothesis in 1982.¹⁸ She compared the effect of 'real' TT with 'mimic' TT, an intervention that mimics the movements of the nurse doing TT but during which there is no attempt to centre, no attempt to assess the subject, no attuning to the condition of the patient and no repatterning or rebalancing taking place. Quinn videoed the interactions and non-participant observers were unable to distinguish which was which. Based on the results of a self-administered pre- and post-questionnaire, Quinn was able to show a greater decrease in post-test state anxiety

scores in subjects treated with 'real' TT than in those treated with 'mimic'. The results of Quinn's study support Krieger's assertion that TT is a healing meditation in which the intention of the practitioner and the ability to remain 'centred' is a vital and necessary part of the therapy¹⁰

Keller¹⁹ examined the effects of TT on tension headache pain, building on previous work done by Heidt and Quinn^{17,18} which indicated that TT decreased anxiety. Reasoning that since anxiety is known to play a role in the aetiology of tension headaches, Keller hypothesized that subjects receiving TT would experience pain relief, that they would experience greater pain relief than a placebo TT group, and that their pain reduction would be greater 4 h after treatment. Her findings were consistent with her claims in the literature that TT can relieve pain significantly

Many other studies of good quality have now been carried out Randolph²⁰ studied the physiologic response to stressful stimuli in college students in 1979. Pain in postoperative adults was looked at by Connell-Meehan in 1985.²¹ Anxiety in hospitalized elderly patients was examined by Parkes in 1985.²² In addition, numerous further studies by Quinn at the Centre for Human Caring at the University of Colorado and Connell-Meehan at New York University have been published since 1987. Some research is beginning now among students of TT who have studied at the Didsbury Trust in the UK.

The need for further research is evident, and is reinforced by Quinn.²³ "The first and perhaps most obvious (need) is the application of TT to a host of real world clinical problems - clinical trials or outcome studies. The second path involves the development of an explanatory model/theory of TT which is validated and refined through the research process."

CONCLUSION

A deepening of understanding around Rogers' field theory as well as continued and replicated studies on TT by nurses is still needed. However, the evidence shows that interest in and commitment to TT has grown rapidly among clinicians for essentially one reason - it seems to work.

TT offers an important dimension in healing and caring for many health care professionals. Research so far suggests that it can bring significant benefits to patients, at minimal cost While helping some patients, no harmful effects have yet been demonstrated when done by practitioners who have been trained by Krieger or her students and who follow the guidelines as set up by the governing bodies of TT.

Currently, the only governing body within the UK is the Didsbury Trust, which is developing TT based on accredited and well-established programmes and is led by an expert practitioner and teacher who was taught by

Krieger. As yet TT is not as widespread as in the US but, since 1989, when the Didsbury Trust achieved charitable status, interest has been increasing rapidly among nurses and is now being taught by the Trust in nursing schools, post basic education departments, and nursing development units throughout the UK.

Like all complementary therapies, TT runs the risk of not being taught and practised in a bona fide way. Hence the setting up of an accredited course for practitioners, the first of which began in the autumn of 1992. Out of these practitioners' classes will come the future teachers and researchers for the UK. While the use of TT continues to expand in the UK there is a parallel need for qualified teachers and a considerable body of research evidence to support its use and deepen its theoretical base.

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